TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Providence Sierra

Respondent Name
Standard Fire Insurance Co

MFDR Tracking Number
M4-24-1741-01

Carrier's Austin Representative
Box Number 5

DWC Date Received
April 11, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 8, 2023	0250	108.10	$0.00
June 8, 2023	0278	28958.00	$0.00
June 8, 2023	0360	25862.00	$0.00
June 8, 2023	0370	5672.00	$0.00
June 8, 2023	0636	1637.00	$0.00
June 8, 2023	0710	6610.00	$0.00
June 8, 2023	WC Adjustments	-63510.90	
	Total	$5336.20	$0.00

Requestor's Position

"The Hospital's records reflect the patient was injured in work related injury. The Hospital provided the medically necessary services on the above dates of service. The Hospital billed Travelers, but the bill was denied. However, despite the Hospital's efforts and Request for Reconsideration Travelers has not rendered proper payment."

Amount in Dispute: $5336.20

Respondent's Position

"Reimbursement is being issued in the amount of $2,633.38 accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation. Reimbursement is calculated at 200% of the Medicare base rate as the Provider did not request separate reimbursement of implantables on the UB-04. With the reimbursement being issued, the Carrier contends the Provider is not entitled to additional reimbursement."

Response submitted by: Travelers

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.403 sets out the fee guidelines for outpatient hospital services.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P18 – Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 5089 – Review of the submitted documentation does not support the classification of stop-loss or outlier for the specific diagnosis or treatment rendered. Therefore reimbursement was based on standard rate.
- 5454 – The operative report is required prior to payment consideration.
- 4915 – The charge for the services represented by the code is included/bundled into the total facility payment and does not warrant a separate payment of the payment status indicator determines the service is packaged or excluded from payment.
- 802 – Charge for this procedure exceeds the OPPS schedule allowance.
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 97 – Payment adjusted because the benefit for this service is included in the

payment/allowance for another service/procedure that has already been adjudicated.

- W3 - Bill is a reconsideration or appeal.
- 957 – Upheld, no additional allowance has been recommended.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the insurance carrier make a payment?
2. What rule is applicable to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered in June of 2023. The insurance carrier made a payment at the time of dispute resolution of $2,633.38. The requestor wished to continue with dispute resolution. The fee calculation based on applicable fee guideline is shown below.

2. DWC Rule 28 TAC §134.403 (d) requires Texas workers' compensation system participants when coding, billing, reporting and reimbursement to apply Medicare payment policies in effect on the date of service.

   The Medicare payment policy applicable to the services in dispute is found at www.cms.gov, Claims processing Manual, Chapter 4, Section 10.1.1. Specifically, Payment Status Indicators and Ambulatory Payment Category (APC).

   DWC Rule 28 TAC §134.403 (e)(2) states in pertinent part, regardless of billed amount, if no contracted fee schedule exits that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section including any applicable outlier payment amounts and reimbursement for implantables.

   DWC Rule 28 TAC §134.403 (f) states in pertinent part the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the *Federal Register*.

   The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by: (A) 200 percent; unless (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

   The Medicare facility specific amount is calculated when the APC payment rate is multiplied by 60% to determine the labor portion. This amount is multiplied by the facility wage index for

the date of service. The non-labor amount is determined when the APC payment rate is multiplied by 40%. The sum of the labor portion multiplied by the facility wage index and the non-labor portion determines the Medicare specific amount. Review of the submitted medical bill and the applicable fee guidelines referenced above is shown below.

- Revenue code 0250 – Pharmacy packaged into primary procedure.
- Revenue code 0278 – No separate request. Packaged into primary procedure.
- Revenue code 360 - Procedure code 26418 has status indicator J1, for procedures paid at a comprehensive rate. All covered services on the bill are packaged with the primary "J1" procedure.

  This code is assigned APC 5112. The OPPS Addendum A rate is $1,434.52 multiplied by 60% for an unadjusted labor amount of $860.71, in turn multiplied by facility wage index 0.8631 for an adjusted labor amount of $742.88.

  The non-labor portion is 40% of the APC rate, or $573.81.

  The sum of the labor and non-labor portions is $1,316.69.

  The Medicare facility specific amount is $1,316.69 multiplied by 200% for a MAR of $2,633.38.
- Revenue code 0370 – Anesthesia, packaged into primary procedure.
- Revenue code 0636 – Drugs, packaged into primary procedure.
- Revenue code 0710 – Recovery room, packaged into primary procedure.

3. The total recommended reimbursement for the disputed services is $2,633.38. The insurance carrier paid $2,633.38. Additional payment is not recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 11, 2024 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3, or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.